MEDICAL PAROLE
AUTHORIZATION FOR RELEASE OF INFORMATION

INMATE INFORMATION

Last Name:	First Name:	Middle Name:	Date of Birth:

Address:	City/State/Zip:	CDC Number:

Person(s)/Organization(s) Providing the Information

Name: California Department of Corrections and Rehabilitation
Address: PO Box 942883
City, State, Zip: Sacramento, CA 94283-0001
Phone Number: (916) 323-6001

Name: Board of Parole Hearings
Address: Post Office Box 4036
City, State, Zip: Sacramento, CA 95812-4036
Phone Number: (916) 445-1539

Person(s)/Organization(s) to Receive the Information

Name: Board of Parole Hearings
Address: Post Office Box 4036
City, State, Zip: Sacramento, CA 95812-4036
Phone Number: (916) 445-1539

and

Medical Parole Hearing Participants and members of the public upon request, pursuant to Penal Code Section 3042(b).

[45 C.F.R. § 164.508(c)(1) (iii) & Civ. Code § 56.11(e), (f)]

Description of the Information to be Released
(Provide a detailed description of the specific information to be released)

[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code §§ 56.11(d) & (g)]

☐ **Medical**	☐ **Mental Health/Psychological**	☐ **Genetic Testing**
☐ **Dental**	☐ **Substance Abuse/Alcohol**	☐ **Communicable Disease**
☐ **HIV**	☐ **Psychotherapy Notes**	☐ **Other (Please Specify)**

_____.

For the following period of time: **From** _____ **(date) to** _____ **(date)**

Purpose for the Use or Release of the Information
(Indicate how the information will be used)

[45 C.F.R. § 164.508(c)(1)(iv)]

☐ **Medical Parole**: The information shall be used to determine medical parole suitability and/or continuing eligibility, pursuant to Penal Code Section 3550.

Will the health care provider receive money for the release of this information?
[45 C.F.R. § 164.524 (c) (4) (i), (ii)]

Reasonable fees may be charged to cover the cost of copying and postage.

This authorization for release of the above information to the above-named person(s) and/or organization(s) will expire on: _____ (date). [45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h)]

I understand:

- **I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i)]**
- **I have the right to revoke this authorization by sending a signed notice stopping this authorization to the health records department at my current institution. The authorization will stop further release of my health information on the date my valid revocation request is received in the health records department. [45 C.F.R. § 164.508(c)(2)(i) & Civ. Code § 56.11(h)]**
- **I am signing this authorization voluntarily and that my treatment will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii)]**
- **Under California law, the recipient of the protected health information under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. [45 C.F.R. 164.508(c)(2)(ii)]**
- **I understand I have the right to receive a copy of this authorization. [Civ. Code § 164.508 (c)(4) and Civ. Code § 56.11(i)]**

Inmate's Signature:	**CDC Number:**	**Date:**

[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c)(1)]

Inmate's Authorized Representative:	**Relationship to Inmate:**	**Date:**

[45 C.F.R. § 164.508(g)(1) & Civ. Code § 56.11(c)(2)]